# FAQs on the Maryland Multi-Payer Pilot Program For Self-Funded Employers

## 1. What is a Patient Centered Medical Home?

A patient centered medical home is not an actual place, but rather is an advanced way to practice primary care. The patient centered medical home model aims to increase quality of care and reduce ED visits and hospitalizations through:

- A team approach of physicians, nurses, care managers and other health care professionals;
- Comprehensive coordinated care throughout the health system, including treatment plans, medication management, visit follow up, etc.;
- Enhanced access with 24/7 availability, email and telephone consults, open scheduling and after hours care;
- Use of health information technology including an Electronic Health Record, e-prescribing, patient registries and decision support systems; and
- An intense focus on wellness and prevention.

## 2. What is the Maryland Multi-Payer Pilot Program (MMPP)?

The MMPP enables self-funded employers to potentially realize savings by averting health care costs while increasing quality of care and improving employee satisfaction through use of patient centered medical homes, or advanced primary care. The MMPP has five major steps to full implementation:

- Employer informs its TPA and Maryland Health Care Commission ("Commission") that they wish to participate;
- Commission staff works with employer to estimate cost to start program. The initial investment is called a "fixed payment" which is paid to primary care practices which care for the employees. The "fixed payment" is based on the quality of care and size of the practice and is expressed as a dollar amount per member per month – the annual "fixed payment" paid by employers per employee will be about $50-60. The fixed payment helps the primary care practice make the changes necessary to provide advanced primary care. In exchange for this investment, the employer will share the resultant savings, as compared to historical costs, on a 50-50 basis with the practice;
- The TPA works with the employer to determine how the "fixed payment' will be transferred;

- The primary care practice informs the patient they are eligible for the MMPP and gives patients the opportunity to opt-out of MMPP; and,
- The Commission calculates the savings/costs realized on an annual basis.

## 3. What incentives do self-insured employers have for participating in the Program?

Self-insured employers who decide to participate in Maryland's PCMH Program will receive both short-term and long-term benefits. In the short-term, self-insured employers could achieve a reduction in the per member health care expenses. An employer could see that reductions in costs in the form of lower claims costs across enrollees participating in the Program relative to the employer's historical spending trend for those same enrollees.

In the long-term, self-insured employers and the health care delivery system should receive more cost-effective and efficient health care. With over 16 percent of our GDP spent on health care, American businesses--self-insured employers and fully-insured employers--face high health care costs which pose a challenge to their competitiveness with businesses in other industrialized nations. By better incentivizing primary care, the Maryland Health Care Commission hopes that Maryland can take a step towards improving care quality, reducing health care costs and over time, improving the competitive edge of Maryland businesses.

## 4. As a self-insured employer, will my reduction in claims costs be shared with participating primary care providers?

Yes, participating primary care providers would receive an additional payment representing up to 50 percent of the net total medical shared savings generated by the practice. For self-insured employers, anticipated savings will be realized as reductions in claims costs and reductions in the overall care costs for enrollees participating in a PCMH practice. These savings are shared with providers in an effort to further incentivize reduced utilization and quality improvements across participating enrollees.

## 5. What medical expenses will be counted for shared savings computations?

All medical expenses will be summed for the base and program year for all patients that are in the medical home in both the base and program years. Medical expenses include employer and reimbursements and patient liabilities for hospital inpatient services, hospital outpatient services, freestanding medical facility services, health care professional services, nursing home care, skilled nursing facility care, home health care, hospice services, and durable medical equipment. Prescription drug spending will not be included because a separate vendor is typically responsible for managing that utilization. Gaining access to that information cannot be completed consistently for all plans.

## 6. As a self-insured employer that uses CareFirst as the TPA, will I have to pay twice if an enrollees' provider participates in CareFirst's Single Payer PCMH Program and Maryland's multi-payer PCMH Program?

No, a self-insured employer will not pay twice for his enrollees' participation in a practice site selected to be part of the MMPP and CareFirst's Single-Payer PCMH Program. Practice sites that participate in the MMPP do not participate in the CareFirst program. A self-insured employer will be responsible through the CareFirst TPA for the MMPP upfront annual fixed payment of approximately $50-60 per

year for any of his enrollees that is a regular patient of an MMPP practice site. No double payment can occur.

## 7. What additional services will my enrollees receive if I participate in the Program as a self-insured employer?

Patients engaged in a Patient Centered Medical Home practice will receive continuous, comprehensive care coordination that draws on a team approach.

Specific services a practice is required to offer include:

- 24-7 phone communication with a clinician for urgent needs.
- Convenient appointments – due to open access scheduling.
- Email and telephone consultations.
- Care management and coordination by specially trained team members:
    - Treatment plans,
    - Preventive and follow-up care,
    - Reminders for medical appointments, and
    - Assistance with self care.
- Medication reconciliation every visit:
    - Reviewing medication for drug interactions, allergies, and lower cost alternatives.
- E-prescribing.*
- Pre-visit outreach and after-visit follow-up by care management.
- Medical record access.*

**Practice sites are required to implement e-prescribing and medical record access by end of Year 2.*

## 8. How will patients know that they are in a Patient Centered Medical Home?

MMPP selected sixty primary care practices sites to participate. These 60 sites will notify their patients in writing of their selection and will invite patients to participate in the PCMH Program. These letters will introduce patients to the concept and benefits of a patient centered medical home.

Based on Maryland law, patients will be able to opt-out and not participate in the Program by simply notifying their provider. In turn, payers, self-insured employers, and carriers, will not be required to provide a fixed care coordination payment for patients who decide not to participate and will not include them in shared savings calculations.

## 9. As a self-insured employer, if I choose not to participate in the PCMH Program, how will my enrollees be treated if their provider is participating with the medical home model?

Patients in participating practices whose self-insured employers decide not to participate in the PCMH Program can continue to receive care from their primary care provider. These patients might not have access to the PCMH practices' full set of services such as comprehensive care coordination or open access scheduling. The PCMH Program will leave the delineation of services provided to patients with participating payers and those whose payers are not participating up to selected PCMH practices.

## 10. How were MMPP primary care practices selected?

MMPP sought applications from primary care providers – family practice, internal medicine, geriatric and pediatric physicians, and nurse practitioners – throughout the State. Because this is a pilot program with prescribed funding, only 60 of the 180 practices that applied could be accepted. A selection committee comprised of payers, providers, and health policy experts knowledgeable about PCMH implementation was convened. The selection committee selected a range of practices that is broadly reflective of the diversity in population and practice style in the State. The selection criteria focused on six main domains:

- Special Requirements in legislation such as geographic diversity, reflecting variations in care delivery, encompassing all populations (Commercially insured, Medicaid, Medicare) and highlighting representation from small practices, Nurse Practitioner-led practices, and practices that are collaborating with other small practices.
- NCQA Recognition, including PCMH Recognition or other NCQA recognition programs such as Back, Heart, or Diabetes Recognition.
- Participation in quality initiatives, employee wellness, primary care residency
- Established business functions such as inclusion of extended hours of access.
- Adaptive financial reserve - the capabilities and resources that can be used to further the transformation to a PCMH.
- Current PCMH features that are in place:
    - Use of Electronic Health Records
    - Offer care beyond "office visits" (i.e., phone, online),
    - Demonstrate tools and processes in place for care management (registry, outreach function & care manager staff, etc.),
    - Follow-up Emergency Department and/or hospital discharge with a proactive and coordinated team approach to care coordination, and
    - Demonstrate timely and actionable communication to your main ED/hospital.

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